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Boundary-making in the Medico-Legal Context: Examining Doctor-Nurse Dynamics in Post-Sexual Assault Forensic Medical Intervention

Abstract

A key dimension of the institutional response to sexual assault is the forensic medical examination of a victim's body conducted for purposes of documenting, collecting and testifying to corroborative evidence. Drawing upon in-depth interviews with forensic examiners and forensic nurse practitioners in one region of England, this study addresses a gap in the existing research on medico-legal processes, and critically examines the nature and dynamics of the relationship between doctors and nurses involved in this intervention. Using an analytic framework based on Thomas Gieryn's notion of 'boundary-work', we explore how this historically gendered dyadic relationship is experienced and understood in a context influenced by both medicine and law. We demonstrate very clear boundaries demarcating a) physicians as experts and nurses as non-experts in the collection and representation of medical evidence, and, b) physicians as equated with technical competence and nurses with 'caring' duties. We conclude by positing implications that may stem from these professional relations with respect to sexual assault evidence, professionals, and victims.

Keywords

forensic medical examination; rape; sexual assault; boundaries; medico-legal; biomedical; doctors; nurses; gender; United Kingdom

Introduction

Sexual violence is an enduring problem across the globe (Htun & Weldon, 2012; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). The state typically has a responsibility to intervene, which occurs most frequently through criminal justice institutions (McMillan, 2011). The burgeoning medico-legal sphere within sexual assault intervention is centred on particular practices, technologies and inter-professional relations of forensic medical evidence collection. If a rape or sexual assault is reported to the police, or if a victim presents to a specialised rape centre or hospital, the subsequent response is likely to involve a forensic medical examination. This paper is concerned specifically with the professional relationships and boundaries between doctors and nurses involved in this intervention. Using a framework based on Thomas Gieryn's 'boundary-work', we explore how this historically gendered dyadic relationship is experienced and understood in a context that is influenced by both medicine and law.

Background

The forensic medical examination is a means of corroborating a victim's account of sexual assault and rape (Du Mont & White, 2007). The examination has two purposes: to collect evidence from the victim's body through observation and documentation of injuries, collection of specimens and swabs (e.g., semen, sperm, urine, blood); and, health care for the victim, including treatment of injuries, post-exposure prophylaxis, screening for sexually transmitted infections, and provision of emergency contraception (Du Mont & White, 2007; Mulla, 2011). The forensic findings may then be used to try to determine the identity of an assailant, use of force and resistance, recent sexual activity and the inability to consent to sexual contact due to incapacitation through alcohol or other substances. Typically, the sealed evidence and accompanying documentation are given to the police for possible use by investigators and prosecutors. It is commonly believed in popular and criminal justice

cultures that this objectively-collected evidence plays an instrumental, if not crucial, role in determining judicial outcomes (United States Department of Justice, 2013).

Forms of forensic medical examination delivery vary across geography and jurisdiction (Du Mont & White, 2007). Points of difference include institutional setting (criminal justice or health care), specific location (police station, emergency room, specialist sexual assault centre) and the personnel primarily conducting examinations (doctors, nurses, or both). To date, a great deal of research has focussed on the Sexual Assault Nurse Examiner (SANE) model mainly found in North American jurisdictions. These programmes are typically delivered in hospital-based settings and conducted by specially trained SANEs who attend to the physical and emotional needs of victims and conduct evidentiary examinations guided by 'rape kits' (Campbell, Townsend, Long, Kinnison, Pulley, Adames & Wasco, 2006). Whilst this research has produced valuable insights, globally the vast majority of forensic medical intervention is not SANE-based, rather, it is delivered using approaches that involve physicians working independently or with the assistance of nurses, or a mixed economy where both doctors and nurses perform the examinations (Du Mont & White, 2007). Further, research conducted on non-SANE delivery has tended to focus on only doctors or nurses. To our knowledge, none to date has looked at the relationship between doctors and nurses in this unique locus, despite the existing body of work examining doctor-nurse dynamics in other biomedical settings (e.g. Carpenter, 1993; Lupton, 2012). In order to address this lacuna, our study examined the practices, perceptions and working relationships of physicians and nurses in the context of the forensic medical examination.

The data used in this paper were drawn from interviews with forensic medical examiners (FMEs) and forensic nurse practitioners (FNPs) in a particular region of England. Historically, forensic medical provision in England has been managed and delivered by the police rather than health care. Whilst the system has evolved over time, typically, doctors

have been contracted by police forces to perform examinations, and the forensic element of the examination has been prioritised over medical aspects (Pillai & Paul, 2006). Research studies in the 1980s were heavily critical of this approach and identified problems such as examinations being conducted in police stations as opposed to health care facilities, the often insensitive manner of the doctor, and a shortage of female physicians (Corbett, 1987; Women's National Commission, 1985). Studies in the 1990s went on to highlight victims' poor experiences of the forensic medical examination process, citing the frequent insensitivity of male physicians as a key factor (Gregory & Lees, 1999; Temkin, 1996). In the 2000s, two joint inspections by Her Majesty's Crown Prosecution Inspectorate (HMCPSI) and Her Majesty's Inspectorate of Constabulary (HMIC) reported that despite some improvements, problems remained. There was evidence of variation in the training standards of doctors, a shortage of female physicians, difficulty retaining physicians, and a minority demonstrating a 'less than sensitive' approach to victims (HMCPSI & HMIC, 2002, p. 23). A later inspection highlighted further concerns about varying levels of expertise and service to victims, inconsistency in how physicians were employed, a growing trend towards private outsourcing, and poor availability of doctors to conduct the work (HMCPSI & HMIC, 2007).

Inconsistency in service delivery was also indicated by Pillai and Paul (2006). Their research drew attention to the differing levels of service offered to victims in areas that had a sexual assault referral centre (SARC) - a specialised service that addresses victims' forensic, medical and support needs in one setting - compared to those offering the traditional model of police-governed delivery. Initially SARCs were slow to develop, and despite a commitment from the Department of Health and the Home Office to establish a SARC in every police force area in England, in 2014 there were 25% fewer than initially envisaged (Cowley, Walsh & Horrocks, 2014). It has been, and remains the case, that in England most forensic medical services are doctor-led and that the vast majority of forensic medical examinations are

conducted by doctors (Love, 2013). Whilst forensic nurses have been able to carry out examinations since 2001, only a small number of areas in England employ them in this role (Rees, 2011). Given the preponderance of the doctor and nurse configuration, it is necessary to critically examine those locations where both are involved in administering forensic medical examinations in order to discern the nature and dynamics of physician-nurse relations in this medico-legal context.

“Boundary-work”: Framing occupational relations in the medico-legal context

To establish our understanding of this forensic medical intervention and relations between doctors and nurses, we drew upon Thomas Gieryn’s notion of “boundary-work” (1983; 1999), a process of “demarcation by which scientific disciplines and modern professions seek to secure their autonomous position, gain legitimacy, mark and defend their turf, and expand their jurisdiction” (Mizrachi, Shuval & Gross, 2005, p. 20). Encompassing a variety of rhetorical and action strategies, boundary-work concerns “the attribution of selected characteristics” (Gieryn, 1983, p. 782) for purposes of delineating borders between actors and activities. Although originally employed in the study of the ideological separation of science and non-science worlds and struggles for “epistemic authority” (Gieryn, 1999), many scholars have appropriated and adapted Gieryn’s concept to explain the ways in which boundaries are established (or eroded) between knowledge realms or jurisdictions in a number of arenas (see for example, Abbott, 1988; do Mar Pereira, 2012; Kerr, Cunningham-Burley & Amos, 1997; Mellor, 2003; van den Hoonaard, 2015).

More specific to this study, “microanalyses of boundary demarcation and healthcare settings have highlighted the ways [] actors’ professional, structural and spatial positions in the hospital setting shape their epistemological, ideological and ethical views of their daily work. These diverse viewpoints acquire visible expressions in daily processes of boundary

negotiations among different medical professions” (Mizrachi et al., 2005, p. 21). Jon Adams (2004), for instance, explored the occupational boundary-work that general practitioner therapists in the UK engaged with in the attempt to confront growing complementary and alternative forms of medicine. Drawing on interview data, Adams examined the “rhetorical strategies” they used in their struggle to demarcate their professional roles as situated on the ‘authentically’ medical side of the medical/non-medical (lay) divide.

Looking at another occupational group in the UK, Bach, Kessler and Heron (2012) observed boundary struggles between nurses and healthcare assistants (HCA) who were undergoing an expansion of their role in the context of institutional reorganization. Highlighting the complex relations of this gendered occupation and the boundary work of nurses and HCAs as centred on the traditionally ‘caring’ dimension of nursing, the authors examined the often conflictual strategies engaged in the process of managing the work domain of each group with respect to patient care. Davina Allen (2000) conducted an ethnographic study of the boundary-work of nurse managers in a general hospital, focusing on the micropolitical dimensions of demarcation activities in (re)producing and formalizing their work borders at the interfaces of medical-nursing and nursing-support workers within a transitioning organization in Britain. This was followed by her 2001 study of the role of talk in the production of occupational boundaries. Through discourse and conversation analysis, Allen highlighted the “atrocious stories” nurses would relay about doctors, illustrating “the ways in which both the *rhetorical form* of nurses’ tales and their storytelling *practices* function to create a moral boundary between nurses and medical staff” (p. 78).

Of course bounded professional roles in the medical context are highly gendered. Doctors and nurses “. . . are, importantly, historically imbued with particular gender relations and build upon certain notions of femininity and masculinity . . .” (Davies, 2003, p. 722). Whilst in contemporary health care settings an individual performing the role of doctor or

nurse may be male or female, gender remains central to these inter-occupational relations (Witz, 1990). These divisions represent a “reductionist sociobiological model of gender role differentiation ... women, as an extension of their maternal functions, possess expressive, emotional and caring qualities, while men are naturally more instrumental, rational, scientific and decisive” (Porter, 1992, p. 512). In analysing such inter-professional relations in the medical sphere, Witz (1990, 1992) identified a number of ways boundaries are established and reinforced in order to reproduce a gendered division of labour and the subordinate position of nurses and midwives vis a vis doctors, in effect “... policing and controlling the boundaries between the occupation of medicine and related occupations in the medical division of labour” (Witz, 1990, p. 679). The gendered strategy of demarcation she described – including, for example, de-skilling - encloses female-dominated occupations within discrete areas of competence and subsumes them to male dominated occupations (Witz, 1992), essentially creating boundaries between what is considered ‘nurses’ work’ and ‘doctors’ work’.

Whilst, as noted above, there exist a number of studies of boundary-making between nurses, other health care workers and nurses, and between nurses and doctors within the traditional hierarchical field of biomedicine, the relations and activities of FMEs and FNPs in the medico-legal arena represents a novel site that has yet to be critically examined. What boundary-work is undertaken within this dyadic relationship? How are FME and FNP boundaries established, reinforced, institutionalized and resisted? Below we explore the interrelations between FMEs and FNPs as expressed in their relative activities and in their perceptions of forensic medical work in cases of sexual assault.

Method

This research, funded by the Economic and Social Research Council (RES-061-23-0138-A), used a case study design and all data were collected in one English county. The project was a large mixed-methods study looking at many aspects of the criminal justice process in relation to rape. Data presented here come from in-depth qualitative interviews with forensic medical staff. Ethical approval for the research was granted by the School of Social Sciences and Cultural Studies Research Governance Committee, University of Sussex.

Criteria for inclusion in the research were all forensic practitioners employed as either a forensic medical examiner (FME) (doctor) or forensic nurse practitioner (FNP) (nurse) who regularly conduct forensic medical examinations of rape victims in the county in question. None were employed solely to administer sexual assault examinations, rather they were contracted to provide all forensic medical services for the police, including persons detained in custody. Just as the research commenced, the contractor providing forensic medical services in this area withdrew nurses from independently carrying out forensic medical examinations of victims. Nurses continued to provide general custody medical services and to forensically examine suspects in rape and sexual assault cases and could still assist physicians with forensic medical examinations of victims. Therefore those nurses interviewed referred to their very recent experience of autonomously conducting victim examinations.

A list of all FMEs (10) and FNPs (19) was provided by the lead FME. Every FME and FNP on the list was contacted and offered the chance to participate. Excluding those who were not able to participate within the time frame of the project, those who did not have recent or any experience of conducting sexual assault examinations, and those who did not respond to email communication, our final sample totalled 11 practitioners. Of these, 7 were FNPs and 4 were FMEs; 8 respondents were female and 3 were male. Only one of the FMEs was female, and FNPs were exclusively female.

The research sample was comprised of all potential participants who were eligible and responded to the request. It is not possible to ascertain whether alternate accounts would have been provided by those who were eligible for inclusion, but chose not to respond to the request. The gender profile of the final sample is in line with the proportions of men and women working in each occupational category. Overall, the majority of forensic physicians are male and as noted above, both recruitment and retention of female forensic physicians is a long-standing problem. Crilly et al (2011) reported that male forensic physicians predominate (66%) where sexual offence forensic medical work is provided within the same service as other forensic and custody work, which was the case for the area used for this research. Similar proportions of male-female forensic physicians are found in comparable jurisdictions; of 63 physicians qualified to do sexual offence work in Scotland, only 19 (30%) are women (HMICS, 2017). Conversely, a high proportion of forensic nurses are female, especially those qualified to carry out, or assist with, sexual assault examinations, with their introduction primarily being driven by the need to offer greater choice of examiner gender for victims (Crilly et al, 2011; Toon & Gurusamy, 2014; HMICS, 2017). Having said this, although the gender make-up of the sample is broadly in line with the professions as a whole, the nature of case study research means the sample is small, which brings limitations in terms of the extent to which we can demarcate differences on account of the gender of the participant or the gendering of the role, or the professional distinctions identified below.

Interviews used a semi-structured approach and were conducted in private locations including forensic medical suites, police stations, and a private home. All interviews lasted between 1 and 2 hours, were tape recorded, and transcribed verbatim. Using an inductive approach, data were analysed systematically by both authors who read and reread the transcripts. Transcripts were analysed as a whole data set initially, and then in the comparative categories of FMEs and FNPs. Each author separately developed analytic

themes based on the data which were compared and discussed. Themes were then refined, revised and developed, resulting in an overarching conceptual framework centred on i) an expert/non-expert boundary and, ii) reification of the ‘competence-care’ divide in medical work. All references to these categories were identified and analysed systematically to establish patterns. The findings below are presented according to these two categories.

Findings

The Expert/Non-Expert Boundary

Within the medico-legal setting examined there was an explicit boundary demarcating physicians as ‘experts’ who possessed the authority to engage in claims-making with respect to what was considered evidence, how it was best collected and interpreted, and by whom. To start, there was universal belief among both FMEs and FNPs that only doctors could be considered ‘expert witnesses’ in a court of law, and that nurses could only be ‘professional witnesses’. Whilst no such legal distinction exists, these terms are commonly used (see for example, General Medical Council, 2013). In fact, the law distinguishes between witnesses of fact, and those able to give expert opinion evidence. A witness's expert status is, in theory, decided upon by the court on a case by case basis based on the witnesses' expertise (Law Commission, 2011) and "is admissible to furnish the court with scientific information which is likely to be outside the experience and knowledge of a judge or jury" (Lord Justice Lawton in *R v. Turner* [1975] QB 834, at 841). However, the belief and practice that nurses cannot give expert opinion evidence in such cases is not limited to our sample, but prevails in both scholarship (e.g. Cowley, Walsh & Horrocks, 2013; Love, 2013; Toon & Gurusamy, 2014) and in guidance given to their members by professional associations (UKAFN, 2017). As Hawkins (1992, p. 11) rightly noted, the social practice of legal decision making is not immediately “predictable from scrutiny of legal rules themselves”, and within forensic

nursing, the practice seems to be ‘as if’ there were a rule preventing nurses giving opinion evidence. This apparently regularized boundary therefore largely constructs doctors as experts with the capacity to provide opinion and interpretation as expert witnesses, and nurses as only professional witnesses or witnesses of fact. As such, the way this is enacted in effect allows doctors to interpret evidence, speculate on cause and ascribe meaning, leaving nurses to merely confirm the observation, collection and recording of evidence. Whilst it is not apparent how this boundary has been established, and by whom, it clearly operates to mark an expert/non-expert divide.

As noted above, for a short time nurses in this area were allowed to conduct examinations independently. Our respondents told us that during that period, if the evidence generated had to be attested to, discussed or defended in court, a doctor would be required, even though he or she had not conducted the examination, had not been present, and would testify by working from a nurse’s report and contemporaneous notes. The removal of nurses from independently conducting examinations in this setting could be seen as further institutional reinforcement of doctors’ expert status. Our findings revealed dynamics that stood in stark contrast to the expanding role of nurses in other settings, particularly those in North America, who are considered to have expert status in the criminal justice system (Campbell, et al., 2006) and who are able to conduct examinations independently.

As it was evident that ‘formal boundaries’ had been established at an institutional level, we were interested in how this expert/non-expert dyad was understood, accepted or resisted by both doctors and nurses. We found that some affirmed the demarcation between doctors as expert and nurses as non-expert not only in relation to doctors’ presumed superiority and status, but also in relation to how they would be perceived in court. For example:

. . . you need a doctor, who can then stand up in court and talk about those injuries and how they may have happened, because I'm a professional witness, not an expert witness, . . . so I can say there was a bruise 2 inches long on her vagina, but I can't say how I thought it got there . . . (FNP4)

. . . it might not be appropriate as a nurse to examine that person, it might need to be somebody like a doctor . . . (FNP3)

Well the expert witnesses are usually doctors who have specialised in their subject, and I'm not specialised I'm just Joe Bloggs really. . . . I am a medical professional, but I haven't got the expertise to comment on rapes really. (FNP7)

It appeared that even if the structure of this forensic medical work were to allow for it, there was a belief among some of those interviewed that this was ultimately doctors' territory. According to some physicians, nurses were not capable of effectively carrying out rape examinations and producing evidence:

They're rubbish, they're complete rubbish, their whole training is wrong for court, because nurses are trained in tasks, they're not trained in complex systems, . . . they're used to following protocols and orders, whereas doctors are used to working independently . . . (FME 2)

. . . because I'm an expert . . . I was able to say immediately . . . the way her [the complainant's] brain is behaving . . . includes confabulation, and . . . what she's saying cannot be relied on in court and I think it is confabulation, I don't think he's

done anything, I don't think he has done what she has said, . . . I mean I managed to sort of nip it in the bud, where the nurses they may not have nipped it in the bud . . . his life would have been ruined . . . (FME 1)

Such statements devaluing nurses can be understood as one means through which physicians discursively demarcated their domain, simultaneously rationalizing the subordination of nurses through assertions of incompetence. As Gieryn has stated, when the aim is monopolization and expansion of professional authority, boundary-making activities may be a resource for the exclusion of “rivals from within by defining them as outsiders with labels such as ‘pseudo’, ‘deviant’, or ‘amateur’” (p. 792). Similarly, they may accentuate “the contrast between rivals in ways flattering to the ideologists’ side” (Gieryn, 1983, p. 791). Clearly, both such rhetorical strategies were reflected in these expressed perceptions of FMEs.

It should be noted that some of the FMEs interviewed did appear to hold more tempered and favourable views regarding nurses and their capabilities. Those opinions, however, were qualified. For instance, in recounting the time when nurses in this region were allowed to conduct forensic medical examinations, FME 3 stated that although physician monitoring and assessment of their work indicated that nurses did not identify as many injuries as doctors, he did feel that one or two of the 10 or 12 nurses were “excellent”:

I've got no doubts that a few of them could be trained up to be very good indeed and be as good as any doctor . . . (FME3).

What was notable here - besides the fact that even when nurses did do examinations their work was surveilled by physicians - was that the highest standard for evidence collection was

considered to be that practiced by doctors, which stands in contrast to parts of the world where nurses (primarily trained as SANEs) appear to successfully dominate the medical forensic evidentiary process.

Numerous studies focused on the boundary-work and professional relations within medical and healthcare fields have documented challenges to hegemonic arrangements (see for example, Timmons & Tanner, 2004). The nurses interviewed in this study offered a mixed response to this particular medico-legal hierarchy. Most indicated, at least, an awareness of this power imbalance, reflecting in some instances, unease and a hint of animosity:

I think there's still some people who [see] you as a lesser thing to a doctor, and definitely in court, . . . there's still that nurse doctor thing . . . which is, I think . . . [what] stopped us doing them, is that they see a doctor, a doctor could have done 2 cases and a nurse could have done 100 but they still see the fact that they're a doctor . . . (FNP 2)

I remember once one of the doctors saying that they didn't feel that nurses should be doing rape examinations . . . [she recounts a night that doctor didn't want to come out in the night to do one, and a nurse filled in] . . . I wasn't very happy and for somebody to say that they don't think that nurses should be doing them, and then they refuse to do the exam . . . we're supposed to work as a team, and some of the doctors, they probably don't . . . you ask them for help, very reluctant to help out and things . . . (FNP 3)

The tacit acceptance of the authority of physicians appeared to reinforce the hierarchy between these professional groups, with some nurses seeming to believe a doctor's expert position as inevitable and ineludible. There were nurses, however, who expressed stronger feelings about these arrangements, questioning the status quo, and demonstrating resistance to both the notion that only physicians can be experts, and to the reduction in the scope of their role. For example:

. . . a lot of the nurses had quite a lot of experience, especially some of the ones that started before me, they'd been doing years of examinations and had gone to court and they'd got successful convictions so it wasn't as if we weren't very good at it, I presumed, I don't know why they changed it. (FNP1)

A doctor with the right experience and the right qualification can, but not every doctor can, and certainly not every doctor should be, . . . they just assumed a doctor is an expert and a nurse isn't, . . . and what got to me the most I suppose is that I'd been doing them for 5 – 6 years, the doctors that had just been employed by [provider name] may have been doing them for 6 months and because they were a doctor they were deemed to be more of an expert than me, although they are still not qualified to give an expert opinion in court, but it was assumed that they would be able to because they were doctors. (FNP5)

Some nurses also asserted that if they were provided with an adequate level of training they would be as equally capable as doctors of carrying out forensic medical examinations, collecting evidence and attesting to injury in rape cases. As such, some nurses

did not see their exclusion as legitimate in relation to doctors occupying expert status by virtue of simply being a physician.

. . . no I think if you train your nurses like that I'd be more than happy, I would have no problem in doing it . . . So from that point of view I think nurses I'm sure would be as capable as doctors and I don't know how true it is, this is just hearsay, but I've heard SOLOs [sexual offence liaison officers] say that they prefer nurses to do examinations rather than doctors. (FNP6)

. . . I would if I was trained, if I was trained properly . . . (FNP7)

I mean some of the doctors we have haven't got the experience that some of the nurses have, . . . maybe they think that having a doctor in the witness box rather than a nurse makes a difference, because it's a doctor, and I still think to the lay person, if you were to ask them, because they're a doctor they must have more experience, even though you know, rubbish you can get clinical nurse specialists, I would like to have specialised in. (FNP2)

It is clear from these extracts that several nurses felt strongly that they could, and should, be doing forensic medical examinations and should be regarded as 'experts' for the purposes of court and criminal justice processes. Nonetheless, the expert/non-expert configuration reinforced by physicians and most nurses (even if reluctantly), supports not only a particular forensic medical hierarchy (that differs from certain other models), but reifies the traditional, and gendered, subordination of nurses to physicians in non-forensic settings. The historic power balance between these medical professionals was apparent also

in the second analytic category that emerged from the data - the divide between ‘competence’ and ‘caring’ in the administration of forensic medical examinations.

Boundaries and the ‘Competence-Caring’ Divide

Through their research on the production of medical knowledge in physician education, researchers Good and del Vecchio Good (1993) provided insights that resonate with the boundary-making activities of physicians and nurses in this study. The authors argued that in medical training, a cultural tension arises between two competing themes - ‘caring’ and ‘competence’ - wherein “‘competence’ is associated with the language of the basic sciences, with ‘value-free’ facts and knowledge, skills, techniques, and ‘doing’ or action’ . . . [and] ‘caring’ . . . is expressed in the language of values, of relationships, attitudes, compassion, and empathy, the nontechnical” (p. 91). Here, ‘technical competence’ qualities are “given primacy . . . and the language of competence has come to be increasingly powerful in expressing the self-worth of the physician [and] in negotiating boundaries among specialties . . .” (p. 94).

We found this pattern characteristic of health fields in general to be strikingly apparent in the medico-legal context of this study, where the scientific capital physicians possessed was key in the boundary-making between the roles and activities of forensic doctors and nurses. Whilst physicians occupied the realm of ‘competence’ based on the demonstration of particular ‘technical’ skills related to examinations and forensic evidence, the nurses appeared to represent, almost solely, the ‘caring’ side of this professional divide:

I think nurses have a better bedside manner and are more sympathetic and empathetic . . . whereas the doctors . . . they’re there to do the medical bit. (FNP 3)

I feel quite strongly that nurses have a better bedside manner than doctors and certainly in my experience of doing joint examinations . . . I do think nurses spend more time talking, explaining, try to make a rapport, building a relationship, making the person feel comfortable . . . (FNP 5)

I've got an excellent bedside manner . . . and the first time I did a rape exam with (the doctor), she said 'you see her, you see her, lie still lie still, now this, this is the hymen . . . and it's all jagged and you can see what that means, that means that she's had lots of sex'. She's a lady lying on the couch, you know, now you cannot fault her (the doctor's) forensic expertise, but actually if that was me I would have felt a bit kind of mauled and like a bit of meat! . . . I'm just so caring . . . whereas the doctor's like right go on get up on the couch let's just do this. . . (FNP 4)

The one part of the job that enabled me to be what I saw as a proper nurse, that caring and sharing, to put somebody at ease . . . I do think nurses take more care and more time. (FNP 2)

. . . I've been told once or twice (by doctors) that I'm taking too long . . . Yes I took too long to spend with the victim, but I feel that is my job and this is the whole thing about nursing, you prioritise what is more important and the last thing a victim needs is to be brushed off. . . (FNP 6)

Physicians also expressed recognition of this constructed division between the caring work of nurses and theirs as science-based, action-oriented and technical in nature.

Commenting on what he felt he had done well as an examining doctor in a particular case, one physician observed:

[w]ell, the sciency bits first of all, . . . we got . . . the examination right, me and several others [doctors], so the findings were well written out and presented properly . . . I think the other bit was that we did the tech bits right. . . (FME 2)

Two others stated:

Nurses are generally empathetic, they're more . . . caring, about the emotional sides, whereas the doctors are very much more you know let's get the job done. (FME 3)

. . . they [nurses] actually failed to develop the expertise [regarding male rapes], because they didn't have the depth of understanding about anatomy, physiology, tissues, they just didn't, . . . and they always saw their role as caring. . . (FME 1)

Of course the competency/caring divide is highly gendered. Technical competence can be considered an important component of hegemonic masculinity (Acker, 1990) and caring is often perceived as an important component of many women's jobs, equated with a feminine attribute (Davies, 2003) and generally thought not to require any specialist training or skill. As such, this competency/caring divide both reflects and determines the gendered division of labour of nurses and doctors.

As the primary marker of competence, the acquisition of biomedical training was key to the boundary-work within this medico-legal arena. The rhetoric and activities related to scientific knowledge and technologies served to delineate and reinforce the boundaries

between the professions. Even when nurses had been permitted to conduct examinations it was understood that tools (boundary objects) such as colposcopes and proctoscopes used for documenting internal injuries were still the domain of doctors. Lines were also drawn with respect to what types and parts of victim's bodies nurses were deemed qualified to investigate forensically. For instance, although they would not routinely conduct examinations on those under the age of 13, who would be seen by a paediatrician, nurses also typically did not examine male victims:

[w]hen we were doing the examinations, it would always be us as the first port of call, unless . . . it was a juvenile, if it was a male rape, then the doctors would be involved. . . and over time it just evolved that actually the nurses should be doing straightforward adult female cases, and the doctors should be brought in to do the more complicated either male rapes or children. (FNP 5)

With respect to parts of the body that each could examine, informal boundaries were drawn between physicians and nurses as well. It was apparent that nurses tended not to conduct anal rape examinations. In contrast to the general sense that they would be competent to carry out 'standard' vaginal rape examinations, and could examine the penises of male suspects, anuses of either gender were out of bounds:

. . . you see, I wouldn't do anal rapes . . . if that was the case I'd have to ring the doctor. (FNP3)

It was not clear from the interviews whether there was any relationship between the boundary around examining male bodies and those around examining certain body parts; so whether

the prohibition on examining men was based on a presumption that it may be likely to include an anal assault. Given that nurses were permitted to examine the penises of male suspects, it seems not all parts of the male body were considered out of bounds.

There also appeared to be tightly drawn boundaries around the nature of injuries that nurses could assess forensically. In fact, some nurses indicated they did not consider the examination and documentation of almost any type of injury to be within their skill set, particularly genital or internal injuries.

. . . when I was doing them, if there were any injuries or anything you weren't sure of, I don't think you'll find a sensible nurse that would ever put herself at risk and write something down that she wasn't knowing, . . . (FNP2)

I think if I saw vaginal tears and things, I would phone the FME because I wouldn't know what to do really, you know, documenting them and stuff, I think I'd want somebody with more experience to do that. (FNP7)

I would wait for a doctor, because I'd think right we're talking about ligature marks, we're talking about multiple suspects, . . . I'd probably stay with her, to comfort her, and I'd get doctor for that ... (FNP4)

There was a constructed line between cases that were deemed 'simple' and those thought of as 'complicated' or 'complex'. Anything other than a 'standard' rape involving vaginal penetration by a penis, leaving little or no demonstrable injury, appeared to be considered the remit of a doctor. What is important to note here is that the prohibition of nurses conducting examinations in cases where injuries were present was not because doctors

were deemed able to provide *treatment* of those injuries. Within this medico-legal setting, any individual requiring treatment would be referred to either a hospital or their general practitioner. As such, nurses' tendency to defer to doctors in this regard was not a matter of reducing complainant morbidity or mortality, but in essence another form of occupational closure, where certain aspects of work, in this case legal work, were regarded as the domain of physicians only. The boundary between these two professional groups was marked by deeming nurses competent only in these 'standard' cases. This clearly resonates with what Witz (1990, 1992) defined as a gendered strategy of demarcationary closure through de-skilling, which she used to describe the professional boundary struggles between medical men and midwives. In that case, a similar strategy was used by medical men who drew a distinction between normal and abnormal labour, the latter of which required instrumental intervention, and could therefore only be attended to by doctors.

Conclusion

This study critically explored the professional dynamics within a key dimension of the institutional response to sexual assault - the forensic medical examination conducted for purposes of the collection and documentation of evidence from the bodies of those who are sexually assaulted. It was our intent to address a gap in the existing research on medico-legal processes - which has focused primarily on either forensic nurses or physicians, independently - and shed light on the relations between doctors and nurses who conduct forensic medical examinations. Based on analysis of our in-depth interviews with FMEs and FNPs, we demonstrated that certain patterned activities, conceptualized as 'boundary-work' (Gieryn, 1983; 1999), produced and reinforced meaningful and firm divisions between the physicians and nurses with respect to their roles and statuses in the evidentiary process. We found very clear boundaries demarcating a) physicians as experts and nurses as non-experts

in the collection and representation of medical evidence and, b) physicians as equated with technical competence and nurses with ‘caring’ duties.

This examination of medico-legal social relations offers an empirical example of boundary-work in a novel context. Through these interviews we gained insight into the relatively stable but at times strained symbolic and social boundaries characterizing this stage of post-sexual assault evidence collection. The degree to which these boundaries are professional/organizational, gendered, or both, cannot be fully determined in this limited study. Nonetheless, beyond a general contribution to the sociological literature concerned with the role and nature of boundaries in social processes (see Lamont & Molnár, 2002), and how the specific perceptions and actions of key actors shape experiences and outcomes such as, in this instance, the monopolization of authority, the ability to exclude, and the power to ascertain legal contributions, we posit a number of practical implications that may stem from these professional relations.

First, from our data there appears a reiteration of the gendered divisions traditionally found between the work of doctors and nurses in other health care and biomedical settings. Despite the unique character of medical activities in a juridical context, the boundaries between physicians and nurses in this study were consistent with many non-forensic doctor-nurse configurations; physicians were granted the powers that accompany assumed competence in evidence collection, whilst the more ‘feminine’ caring activities attributed to the nurses tended not to be privileged or respected in the same way. What was striking to us was that the power the physicians appeared to hold in this milieu allowed them a notable degree of discretion and subjective input in any given rape examination, including, for instance, determining what evidence was or was not collected, as well as making assumptions (ostensibly rooted in ‘technical’ knowledge) regarding the veracity of any particular complaint. Whilst this authority accorded physicians resulted in part from the

informal but firm cultural assumption that claims made about the existence and nature of forensic medical evidence are the territory of physicians, this presumption was reiterated at this interactional level by nurses themselves, several of whom reported that they believed doctors had more technical expertise, and as such would frequently defer to them. We submit that the physician's role and the dynamics within this forensic intervention model may shape evidence and individual cases in ways which could potentially undermine both the outcomes for some rape victims, and the underlying presumption within criminal justice systems that medical evidence is factual and objectively collected.

Second, it is notable that some nurses expressed resistance to the assumption that they were not, and could not be, just as technically competent. Several indicated a belief that with appropriate training and experience they could reach the desired standard. It is also worthy of note that whilst they suggested that additional training could make nurses as technically competent to conduct examinations, neither nurses nor physicians suggested further training for doctors to improve their capacity to provide the caring aspect of forensic medical work, indicating neither group perceived a deficit on the part of physicians. This stands in stark contrast to some of the findings of service reviews and research from the 1980s to 2000s discussed above that highlighted the insensitive manner of some doctors as a persistent difficulty in forensic medical provision (see for example HMCPSI & HMIC, 2002). It is likely that if the hegemonic arrangements continue to be accepted in this forensic medical setting, doctors may never be challenged to improve their responses with respect to care, and nurses never allowed to develop 'technical expertise', leaving both professions potentially diminished, and very possibly a poorer experience for the victim.

Moreover, as previous research has identified an on-going problem with the availability of adequately trained forensic physicians, and in particular female forensic physicians (Corbett, 1987; HMCPSI & HMIC, 2002, 2007; Women's National Commission,

1985), to remain entrenched in this 'doctor as expert, nurse as non-expert' dyad becomes an obstacle to reform or innovation in services that might allow a greater role for nurses. In terms of the nurses, such boundaries circumscribing what are and are not legitimate activities and functions can limit their capacity to develop within their professional careers (unlike those in many North American settings), thereby operating as a form of occupational or role closure (Witz, 1990, 1992) and sustaining a deeply entrenched gendered division of labour. This is all the more striking given it was clear that many of these nurses did in fact have the experience necessary to perform the required forensic tasks. Nonetheless, these capabilities were eclipsed by the credentialed training and status of the physicians. Our findings with regard to the expert/non-expert and the competency/caring divide clearly mirror long-established gender division in the doctor-nurse dyad, and patterns of occupational closure through strategies of demarcation (Witz 1990, 1992).

Finally, we contend that there may be significant implications for victims of sexual assault who experience this model of forensic intervention, with its constructed professional divide that so strongly privileges 'masculinized' evidence collection and technical competence whilst taking 'care' for granted. Compared to those in other jurisdictions, caring, which has been shown to be an extremely valuable part of the forensic medical examination for victims (Du Mont, White & McGregor, 2009), may be lost given the subordinated role of nurses and the tensions across the physician-nurse relationship.

We suggest that there would be value in conducting further research that examines nurse-doctor relations in a medico-legal context in locations where nurses are permitted to perform forensic medical examinations in sexual assault cases. Such comparative work could indicate similarities and differences in relation to this study that might help explain the extent to which particular power dynamics result from the nature of taking a lead role in an evidentiary examination and/or which stem from more traditional physician-nurse boundary

work, and/or power relations of gender. Further, given that male forensic physicians predominate (66%) in medico-legal contexts where sexual assault work is combined with broader forensic medical and custody work, whereas female physicians predominate (95%) where sexual assault work is commissioned as a singular service (Crilly et al, 2011), additional research on this latter model of standalone sexual offence service provision that examines physician-nurse dynamics may shed greater light on the nature of these inter-professional relationships and associated boundaries. Studies of the relations between those representing law and those conducting forensic medical examinations would also be of great interest and value.

Lastly, the legal uncertainty and misunderstanding that continues to surround forensic nurses and their capacity to provide expert testimony in court identified in this research, and which is frequently erroneously cited in scholarship and professional association guidelines, requires further research and scrutiny to establish both its aetiology and its persistence. This would shed light on boundaries not only between the medical professions, but also between the legal and medical professions. This is important not least because it continues to be used as a justification for limiting the use of forensic nurses in sexual assault examination work, despite no evidence of criminal cases being compromised by a nurse providing medical evidence rather than a doctor, and when expansion of the role may ameliorate some of the acknowledged challenges facing this aspect of health care delivery, including the scarcity of female forensic physicians (Crilly et al, 2011; Toon & Gurusamy, 2014; HMICS, 2017).

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